Vocabulary Task Force
Draft Transcript
October 22, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good afternoon, everybody, and welcome to the Clinical Operations Workgroup Task Force on Vocabulary. Let me do a quick roll call. Jamie Ferguson?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Present.

Judy Sparrow – Office of the National Coordinator – Executive Director
Betsy Humphreys?

Betsy Humphreys – National Library of Medicine – Deputy Director
Present.

Judy Sparrow – Office of the National Coordinator – Executive Director
Clem McDonald or Stuart Nelson? Marjorie Rallins? Stan Huff?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Present.

Judy Sparrow – Office of the National Coordinator – Executive Director
Chris Chute? Marc Overhage?

Marc Overhage – Regenstrief – Director
Present.

Judy Sparrow – Office of the National Coordinator – Executive Director
Daniel Vreeman? John Klimek? Floyd Eisenberg? Karen Trudel? Don Bechtel?

Don Bechtel – Siemens Medical – IT Architect, Standards & Regulatory Mgr.
I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Patty Greim?

Patricia Greim – VA – Health System Specialist: Terminology
Present.

Judy Sparrow – Office of the National Coordinator – Executive Director
Jim Walker? Andy Wiesenthal? Bob Dolin? Eric Strom?

Eric Strom – DoD Military Health System – Program Management Support
Present.

Judy Sparrow – Office of the National Coordinator – Executive Director
Nancy Orvis? No. Lynn Gilbertson? Marjorie Greenberg? Okay. Jamie, I'll turn it back to you and Betsy.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Thank you very much, everybody, for joining today. What I'd like to do is focus our conversation today on some of the key areas that resulted from the hearings that we had recently. Particularly I think in the last HIT Standards Committee meeting we really reviewed some of the key questions around intellectual property and talking about how we would like to recommend making vocabulary content and related works most easily available for implementers of EHRs, technology and the meaningful use program.

What I was hoping we could do today is to focus on a couple of the thoughts that came out of that Standards Committee discussion around making recommendations for either national licensing with a fee recovery or having an administrative capability administered by the government to manage intellectual property issues, essentially to have one-stop shopping to make it easy for the implementers so that they would basically just cut one check to one place regardless of what the scheme was. My hope was to come around to that, but that first we would have a discussion here today just to make sure we were aligned on the scope of what kinds of intellectual property with regard to vocabularies are we talking about, because some of the focus has been on, certainly, CPT and some of the medication vocabulary cross maps, but I think that we also have to consider the content sets that are used, for example, in X-12 transactions.

Does that sound like an appropriate agenda? I guess this is my way of reviewing the agenda for today's call. Does that sound like the right topic for today or are there other pressing matters that folks would like to discuss?

Clem McDonald – Regenstrief – Director & Research Scientist
Jamie, this is Clem. I don't have a pressing matter, but I got in just after the roll call passed by the Ms or something, so I just wanted to let you know I'm on the call.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Anybody disagree with that agenda for this call or have a different idea? Okay. Well, hearing no disagreement then, Betsy, you had sent a note back yesterday proposing some of the scope for this discussion. I think that what you had described—and for those on the call, this was just between the two of us—was really focusing on the government support for the terminologies and classification systems that already have government support, including ICD-9-CM, 10-CM/PCS—

Betsy Humphreys – National Library of Medicine – Deputy Director
Jamie, where I was coming from—and as I say, I'm very guilty of this—we had a call from this group and I can't remember when the last one is, but the last call we had, and a number of people on the call were giving rationales or reasons that were, in essence, in support of the position of up front, federal support for some of the terminology standards being, in some ways, a more practical way to go than attempting to figure out who needed to be licensed and collecting license fees from all of them. I don't think I dreamed this conversation, but I think we had it.

While we were having it, it occurred to me that sometimes when people are talking about government support for things like terminologies, clinical terminologies, it's like this is a huge new notion suddenly that sprang full blown from the head of Zeus maybe at the time NLM put together a coalition to provide support for LOINC and then going on to the SNOMED license. But in fact, it occurred to me that this is the same model that is used for big chunks of what is required content for administrative transactions and has been the case going way back, since the federal government does support a number, not all certainly, but a number of the key systems that have to be used for statistical reporting and billing and the ICDs, HCPCS, CRGs, etc.

So that's all. I had brought that point up in the last call and—

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. So then to rephrase that or to maybe take off from that point then, the point being that the additional vocabulary content and classification system content that is required for demonstrating meaningful use of an EHR perhaps could even be thought of as a relatively small increment on top of the other vocabulary content that already gets government support up front.

Betsy Humphreys – National Library of Medicine – Deputy Director
Or at least that we're just following a model that has existed for decades.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right, an established pattern. Yes. I think that where we ended up in that last conversation was that we would want to have at least a cost analysis or that we would want to recommend rather to HHS at least that there should be a cost analysis, or cost benefit analysis of two alternatives: One alternative being one having to do with essentially administering some sort of a fee collection scheme for those folks who use these content sets and the other one being some form of up front licensing. Do we still think that that's the right direction for a recommendation or is this conversation shifting towards a belief that really just the straight out national licensing is the right thing?

Don Bechtel – Siemens Medical – IT Architect, Standards & Regulatory Mgr.
Jamie, I did send you some information, which I know you saw, reflecting what I guess the X-12 was thinking in terms of licensing. I think our organization would be open to either approach of having a national licensing scheme or finding some way to collect fees and repay the organization, but the key concern that X-12 has, and I'm sure many other standards setting bodies, vocabulary bodies would have is that the revenue that one collects for these code sets is something those organizations are very dependent on to be able to collect enough money to actually do the business of creating those standards and maintaining them. So if there was a national licensing fee program then the fees that would be paid to those entities would have to match the fees that we could anticipate receiving if individuals were coming directly to us for that work. At least that's where we think we are, because otherwise those organizations begin to lose revenue that they're very dependent on and that will create other problems for the organizations.

Betsy Humphreys – National Library of Medicine – Deputy Director
One of the things that I think is always important to tease out in these different models when you're discussing them is what is the universe of people, who currently are required to purchase the standard and make use of it. Don, maybe you can make sure that I'm on the same wavelength with you; for the ones that ... your message, who in fact pays for them now? I mean what universe of payers?

Don Bechtel – Siemens Medical – IT Architect, Standards & Regulatory Mgr.
What universe of organizations pay for our standards?

Betsy Humphreys – National Library of Medicine – Deputy Director
Yes.

Don Bechtel – Siemens Medical – IT Architect, Standards & Regulatory Mgr.
It would be those organizations that want to use the standards, so basically what they would do is purchase the standards from X-12, the version that they want to have, so they would be able to have a book of the standards and the constraints and things that are set around those standards based on what they're purchasing. So if they were buying healthcare, the transactions for healthcare, there would be a fee for that and they would have free use of those standards.

Betsy Humphreys – National Library of Medicine – Deputy Director
As I say, I should know this, but just to be sure that I am not thinking about this incorrectly, the group or a person or an organization that would do that, would that be a vendor that was building software that made use of it? Would that be a hospital or an insurer that had to send the transaction? Who would have to have bought that?

Don Bechtel – Siemens Medical – IT Architect, Standards & Regulatory Mgr.
For the most part it would be the vendors who are building the applications for those purposes, but many hospitals and payers alike have homegrown systems. So they too would have to be purchasing, but those people who buy the products from the vendors would not need to, although many do.

Betsy Humphreys – National Library of Medicine – Deputy Director
Yes. So I think we need to always keep this straight, because there are models where the people who have to buy the standards are system developers.

Don Bechtel – Siemens Medical – IT Architect, Standards & Regulatory Mgr.
Generally that's true.

Betsy Humphreys – National Library of Medicine – Deputy Director
Yes, whether they just like to have it I mean or whether they build their own systems or they buy them from a vendor then the vendor has done it. In part what happened with these control terminologies, which is the same as what is in place, for example, for the ICD is that those have to be implemented by, in essence, everyone who creates a health record or sends a message, I mean by practitioners, by hospitals, by whatever. They have to be used by a much broader universe and, in essence, part of the reason why we ended up doing some of the things and NLM was involved with other government agencies in setting up was that we basically could not support the ongoing development of terminology consistently, something like LOINC or RxNORM or SNOMED CT with just the level of a reasonable fee coming from vendor organizations or people who build systems. In fact, the pricing mechanisms that were used previously for SNOMED CT involved charging everyone who made use of the standard in actual data creation, so that meant like a physician office or a hospital or a public health department or whatever.

So when we think about what our alternatives are and our fees and whatever, I'm in entire agreement with you that we don't want to come up with a model that doesn't provide the level of support that is required for things that appear to be working well today, but we also really need to keep this thing straight, because for some standards a model that just charged fees to system developers would absolutely not return sufficient funds to actually do the maintenance and dissemination of the standards. At least we couldn't' figure out a way it was going to in the rules. Somebody has a brilliant idea now that's different.

Then the other issue, of course, was how do you determine—? I mean how do you collect the fees and how do you ensure that everybody who needs to pay in has actually paid in when you really are talking about potentially every health professional in the country and, who knows, maybe the patients as well when we get to certain types of personal health records and data entered by patients on their own behalf. So sometimes when we discuss these things I think we end up with a lumping function that really doesn't apply.

Don Bechtel – Siemens Medical – IT Architect, Standards & Regulatory Mgr.
That is true, but on that point about who has acquired the standards, one of the points I made in my e-mail was that it's important for X-12 and, I would imagine, other SDS as well to know who has actually purchased those standards, because we do periodically update them. What we would normally do is push out information to those entities so that they can acquire those updates. Without having knowledge of who they are we wouldn't be able to do that.

Betsy Humphreys – National Library of Medicine – Deputy Director
Well, that's actually also a justification in some circumstances for requiring people to have licenses even if they don't have to pay for them.

Don Bechtel – Siemens Medical – IT Architect, Standards & Regulatory Mgr.

Yes. Exactly.

Betsy Humphreys – National Library of Medicine – Deputy Director
That is the model that we follow with the distribution of some of the vocabularies, because you need to be able to get out to them with the next set of information they need.

Don Bechtel – Siemens Medical – IT Architect, Standards & Regulatory Mgr.
Yes. Exactly. Especially if you have corrections that need to be made ... those kinds of things that they need to be aware of.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Let's get back to just talking about the scope then. What scope are we really talking about for this recommendation? We had some discussion about value sets that may potentially need to be licensed for particular measures from measure developers. I didn't hear Floyd on the call, but I have to confess that's an area I'm not so familiar with.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
I am on the call. I think at the moment the measure developers, who are developing sets, are interested in it being known that they created them. I'm not sure that they're necessarily thinking of charging for them, but many times the sets are specific to proprietary terminologies and that's the problem. So you could get it, but you can't actually do anything with it unless you have a license. So if you were to implement the quality measure you can't without buying the license to the entire terminology. Is that where we want the industry to be? Is there a possibility, for instance, that I could, by taking a quality measure, have only those codes and use them and understand what they are so I can implement this measure even though I'm not using that terminology, say, for billing, which is what it was geared to? That's the question that came up.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I'm sure.

Clem McDonald – Regenstrief – Director & Research Scientist
It might be worth then trying to at least anchor the fact that the ... sense is that these measures won't be licensed for a fee. We maybe ought to anchor that or lock that down or we wouldn't want to go in that direction.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
I would agree.

Clem McDonald – Regenstrief – Director & Research Scientist
Then the second part is I guess no one is naming names, but there is only one proprietary code that we're talking about and most people do have licenses to it.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Yes.

Clem McDonald – Regenstrief – Director & Research Scientist
The question is could one simply state in the document that you have to own a license to this to use it and just kind of trust the world to work on it? That's kind of how it happens now with a little bit of now and then sort of trust here and there. I mean that kind of works. You don't have to do anything as the deliverer of the measures. It probably would all work. Am I wrong somewhere?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Well, no. You're right. It's just that at the moment the way it's set is I can give you the codes, but can't tell you what the descriptors are and I can't tell you what they mean.

Clem McDonald – Regenstrief – Director & Research Scientist
Ah, so we should probably try to negotiate something different.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Right.

Clem McDonald – Regenstrief – Director & Research Scientist
Because the measures are useless without that.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
That was the concern.

Marjorie Rallins – AMA – Director, CPT Clinical Informatics
We're actually having that code and descriptor discussion. It's an ongoing discussion at AMA. We're definitely supportive of the effort and we're trying to move those discussions along so that the descriptor is available. I don't have a final answer for that, but we're working on that now.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Is the idea there, Marjorie, that that would just be the descriptions for those codes that are used in these particular value sets?

Marjorie Rallins – AMA – Director, CPT Clinical Informatics
Correct. So you wouldn't have access to the entire CPT code set. I'm actually sitting here with Matt Manning, who manages our Intellectual Property Department, because I just think he should be with me when we have these discussions. He's saying hello to everyone, but that's correct. It wouldn't be the entire CPT code set, for example. It would be those that are appropriate for that particular value set.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right. So it would be essentially as part of content sets that are used in the meaningful use program, whether for a quality measure or a process measure or whatever the particular measure is.

Marjorie Rallins – AMA – Director, CPT Clinical Informatics
That's correct. Those discussions aren't final yet, but I wanted to let everyone know that they are certainly on the table here at the AMA.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
The other concern I had had was we haven't heard from any individuals, but periodically the question came up if one organization develops a value set for a specific concept, say it's a specialty society, could they be expected to obtain fees for the use of that set in any measurement or clinical decision supported algorithm or, unless there is some restriction on that that's a possibility too, so it could be a SNOMED related value set, but how do we know that if each value set incrementally is added, there's a cost to each one and it's added to manage or measure that could make the cost problematic. So I wasn't specifically only relating to CPT, which is the terminology I understand and Marjorie addressed that. What I was concerned about is to make sure that a value set from a specialty society for a specific condition or procedure or process, if each one attached some dollar value or cents value to that, if that's the direction we wanted to go that's one thing, but I just wanted to bring up that that's potentially a problem.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Okay.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Now, I'm going to try to take this in a slightly different direction, but still staying with the scope question. What about cross maps for the medication terminologies that are a part of RxNORM? Is that a real issue or is that just hearsay as a real issue?

Betsy Humphreys – National Library of Medicine – Deputy Director
I believe that as it stands right now it's an issue in the sense of for some of the heavily used systems, like First DataBank. In order for you to get what you really need to have a full mapping into RxNORM you need to get something else from them and they may have an additional price for it. I believe that the situation may be somewhat like Marjorie described where there are some discussions going on within the company about this and maybe that situation might change, but I don't think there's been any real announcement or maybe definitive decision made.

Marjorie Rallins – AMA – Director, CPT Clinical Informatics
Betsy, were you asking me if there's a decision that's been made?

Betsy Humphreys – National Library of Medicine – Deputy Director
No. I was just saying that I believe that First DataBank is having some discussions about what mappings to RxNORM they currently have and how those would be made available and whether they may change the terms under which they're available.

Marjorie Rallins – AMA – Director, CPT Clinical Informatics
I see, similar to what the AMA is—

Betsy Humphreys – National Library of Medicine – Deputy Director
Yes. Right. Similar, but it's a different issue.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay. So now I wonder are there any other content sets of terminologies or classification systems that are used in meaningful use that we have not talked about, just to continue, to hopefully wrap up the scoping question. Okay.

Then, so with that in mind then, let's move on to sort of what recommendations we might want to make to the Standards Committee eventually to go to ONC. So it sounds as if there's very good support in the Task Force for basically a national licensing scheme as at least one alternative and then I think a question to be asked about that in terms of our recommendation is whether we want an alternative for that to be free to the users and/or an alternative for the intellectual property to come along with a fee associated with it in some form. So basically, having heard some feedback already from ONC staff essentially against making it free, do we still want to recommend that?

Betsy Humphreys – National Library of Medicine – Deputy Director
Against making what free?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Intellectual property that would be required for use, for demonstrating meaningful use.

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How do you make it free?

Betsy Humphreys – National Library of Medicine – Deputy Director
Do you mean providing it in some way that's free to the users?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

That's free to the end user, right. That's what I mean. When I say free I don't mean not paying the owner or the holder of the property rights. I'm saying making it free to the end user, to the meaningful use applicant, whether it's an eligible provider or hospital or MAO.

Betsy Humphreys – National Library of Medicine – Deputy Director
Is Doug on the call? I would have asked him, but one of the things I think we really do need to do is clarify what everyone is talking about when they say that. My other point: Which set of standards are they talking about? Do you see what I mean? Are they talking about all of them, so that their goal would, in effect, be to move to an environment where the federal government wasn't paying for things we're already paying for—

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Oh, I see.

Betsy Humphreys – National Library of Medicine – Deputy Director
Or are they just saying they don't want to pay for any more? What are they saying? Are they thinking that they don't want to undo the model that Don described for those kinds of documents? I mean it just gets back to my question about when we're saying this, all of these things are relevant and all of them have vocabulary in them or ... value sets, but when we're talking about this what are we really talking about? I mean when things are said like that I'm sure they have good meaning, but do we all understand what is meant, you know?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes. No. I don't have those answers, certainly.

Betsy Humphreys – National Library of Medicine – Deputy Director
Well, I think that it could be that when we're thinking about this model we might think about whether the model of some sort of fee structure administered in some way, how applicable that is or how viable that is as a model for certain kinds of standards that we have to use and whether we think it's actually applicable across the board or not?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right. I'll just say my own interpretation of the comments that have been made previously was essentially along the lines of not wanting to pay for any new or any more standards just as a part of this program, but not wanting to upset programs that were in place as a result of administrative simplification and other things.

Betsy Humphreys – National Library of Medicine – Deputy Director
Yes.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
But I think your point is very well taken that we really should then get clarification on what's meant by that, particularly with regard to, I think, the SNOMED license.

Betsy Humphreys – National Library of Medicine – Deputy Director
Well, the other thing too is that I think that looking at what we're talking about now in relationship to what exists already in terms of who pays for what standards on the administrative transactions, maybe we need to see if we can figure out a way to lay that out and then look at what is the same or different about standards that now people are going to have to use with meaningful use and whether doing something analogous to what is currently place for the administrative standards makes sense or whether there are any factors that are so different in the environment of electronic health records or meaningful use transactions that the analogy kind of breaks down. Maybe that would be a useful thing for us to figure out how to do.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes.

Betsy Humphreys – National Library of Medicine – Deputy Director
I'm not saying the analogy would break down. I mean maybe it wouldn't.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right. Right.

Betsy Humphreys – National Library of Medicine – Deputy Director
Of course— Yes.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I like that idea a lot of essentially coming up with a way of describing who pays for what standards today under all of the programs that apply to eligible professionals and hospitals and meaningful use and then seeing what's different about these particular transactions. I like that.

Betsy Humphreys – National Library of Medicine – Deputy Director
I mean I think maybe—

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
That just makes more work for us to do that analysis and put that together, but that sounds like a very reasonable next step.

Betsy Humphreys – National Library of Medicine – Deputy Director
Well, maybe we can figure out getting some help from somebody to help do it—

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes.

Betsy Humphreys – National Library of Medicine – Deputy Director
Because I don't know; I think it could be instructive.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay. Let me just ask perhaps an even more fundamental question and Marc Overhage, I heard you on the call—I'm not sure if you're still on, but I'm wondering—I think you weren't able to participate in the hearing, but I'm wondering from your perspective of participants in the Indiana Health Information Exchange how big of an issue is IP in terms of implementation. Is this an issue that people see as a very significant barrier?

Marc Overhage – Regenstrief – Director
Not day-to-day. The reason I say that, I think the reason that that's true is that, number one, the code sets that are used within their systems, whether it's their laboratory system or their hospital information system, are usually licensed through the vendor as part of that implementation or they just sort of view it as a cost of doing business to have the medication license as part of what they do for their firm—

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right. Right.

Marc Overhage – Regenstrief – Director
We in the exchange, thank you, Clem, rely exclusively on code sets and standards that are widely available, so RxNORM and LOINC and those sorts of things, so we don't run too much into that wall, although certainly we have in the past. There have been some tangles with SNOMED prior to the new licensing arrangement and things like that. That having been said, that also means that we're not

necessarily providing a lot of support. I mean we do for LOINC of course, but for other things we're not necessarily providing support for that work. We're just sort of a free rider on it.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right. I think—

Marc Overhage – Regenstrief – Director
Clem, you might want to amplify on that, because this is a space I don't think about every day and so I sometimes get it wrong and you obviously know a lot about what we're doing.

Clem McDonald – Regenstrief – Director & Research Scientist
Well, when I was there we didn't face any of those problems except, again, when we were trying to do pathology reporting when the SNOMED codes were in a different world. I'm not a business person, so I don't think about support very well, but I think that it largely hasn't been a problem.

Marc Overhage – Regenstrief – Director
Yes.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay. Some of the concern that was expressed around the use of these content sets for meaningful use had to do with the potential complexity of having to track the use of IP that was held or managed by different entities for different parts of the meaningful use program and essentially so that providers and hospitals, if they had to send a check, that they would just send one check to one place and know how much it was. That was essentially the objective that we set out for this activity here.

Clem McDonald – Regenstrief – Director & Research Scientist
Well, to clarify or maybe to expand on the discussion a few minutes ago, in the context of an IHE you're grabbing your codes from the sources of the codes and signing agreements perhaps or putting on the Web the agreement. That's different than bundling them all together; maybe different than bundling them all together and doing something. But on the other side of it, I think the main problem is in the meaningful use criteria. The one problem might be solvable with further discussion with the AMA and I think, to go to Floyd's comments, I would discourage or forbid or disallow other developers of meaningful use things to putting license agreements on that cost something, just because it will impede the whole process.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Well, I mean this certainly just makes me wonder, frankly, how big of a problem this is and are we swatting a grasshopper with a nuclear bomb or something.

Marc Overhage – Regenstrief – Director
One of the concerns I have is we're in a new area where we haven't been sharing things at this level before and now that we are, I don't know the answer to your question, but we're now sharing much smaller value sets and doing much more work. I just think having some rules of the road in the beginning are what's important. That's what I'm looking at.

Betsy Humphreys – National Library of Medicine – Deputy Director
So a question would be do we know enough about what's going on here to define how we would like it to work so we could then work through what's going to prevent it from working that way?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Well, you know, I think what you suggested earlier, Betsy, of basically coming up with a consistent way of describing who's paying for what standards today of those stakeholders who are participants in the meaningful use program, who's paying for what today, how are they doing that and then what's the same or different about what they're being asked to do under the meaningful use program. It seems to me that we need to look at that in order to answer your question.

Betsy Humphreys – National Library of Medicine – Deputy Director
Yes. Then the other part of this would be if I already am paying for something and now that something is going to be part of N number of value sets am I going to be asked to pay again or not. It might even be reasonable for me to be asked. There has to be some additional level of support because the fact that I either have, via some mechanism established by the government or elsewhere or because I license it, have access to the entire code set or vocabulary doesn't mean that anything that whoever is paying for that, whether it's me or the federal government or somebody else, has also provided any level of support for the ongoing development and maintenance of value sets. So where is the funding coming to pay for that?

I think that that's not an argument against what I said before. I think we should do it, but then we need to think about what additional work is now being ... because of meaningful use and how is that work going to be reimbursed going forward.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
What's interesting to me is the discussion that occurred in some of the testimony about what organization, like PHIN, the Public Health Information that CDC does and that NCI does with Mayo in what's developing as SHARE, a lot of some of the use case discussions that they've had support this, but the question is, the couple of concerns that came up in focusing on proprietary issues, but a bigger concern is to say the same thing using a value set of, say, SNOMED concepts and another organization wants to say it and uses a different set of concepts; the concern is the semantic interoperability is gone and if there were some way to allow reuse of those concepts when there is the same meaning and make that available for reuse requires some central way of sharing. That's really the focus that I've been trying to address, less than the proprietary issues and I think that's something that would merit a recommendation that there needs to be some central mechanism for sharing and vetting to make sure that the value sets mean what they're supposed to mean.

Betsy Humphreys – National Library of Medicine – Deputy Director
I agree with that.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes, because I think that's really where I'm seeing the problem is; I shouldn't say problem; some of the issues as we look at some of the retooling when we have different developers looking at different concepts. Is there a public vetting of the value sets that are developed to make sure they mean what they're supposed to mean? All of these questions come up, but there's no central place to go and identify something identified for clinical care. Does that same value set apply when I think of the quality measure? Does it apply when I think of decision support? Does it apply when I'm thinking of heart failure in the context of a patient who has an MI versus another patient who hasn't had an MI? I mean all of those kinds of things come up and I realize this is complex, but if we're talking about measuring and having funding being applied to that or being paid based on how I'm measured as an individual clinician, all of those issue are very significant.

Betsy Humphreys – National Library of Medicine – Deputy Director
Well, I definitely agree that this is an area that we should also address.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Yes. I think the other thing I'd bring up is if we suggest that each domain has to manage this themselves the same way as there has been and it's under government funding that SHARE is developed and PHIN, VEDS and there's another location for sharing value sets in the HITSP value sets that were created at USHIK and so there are multiple locations that are being funded and efforts, the question is how do they coordinate and rather than suggesting that another set of that capability be developed it would be nice to have a central coordination of it. I think that's a recommendation that would be very helpful to the committee.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
That sounds like a further elaboration on our previous recommendation about ... a central coordinating office or agency, right?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Yes. It's a central coordinating agency or organization, but also it is more detailed around that—

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes, it's enumerating some of those responsibilities—

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Right.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
So, Floyd, it sounds like you may want to volunteer for drafting something for the Task Force members to consider on that.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Sure. I'm happy to. I think my testimony that I gave last round might say a lot of that, but I'll be happy to draft it.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Well, but if you could put it in the form of a simple recommendation for us to consider that would be ideal. But now, getting back to the IP issue that we started on and thinking about how to make that go away as an issue, frankly, for applicants for the meaningful use incentives, I guess to perhaps boil it down too simplistically, it sounds as if there may not be too much of an issue, at least in stage one, but that we probably want to consider how to avoid what we see as potential issues for stage two. Is that a fair assessment or is that really over simplifying?

Betsy Humphreys – National Library of Medicine – Deputy Director
I don't know. I haven't thought about it exactly in those terms. Of course, I'm not out there trying to do the measures and stuff the way others are.

Marc Overhage – Regenstrief – Director
As you just heard, I'm processing this on the fly. What will be different in stage two or three from stage one—?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right. What I'm thinking about in terms of stage two is basically just more measures with more value sets that would have the kind of issues attached to them that Floyd mentioned. I think that's the main difference, isn't it?

Marc Overhage – Regenstrief – Director
So it's a quantitative difference, not a qualitative difference?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I think that's actually right.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
I think it is. As I start thinking about where measures are going though, thinking about patient engagement and care and patient shared decision making, we may be starting to get into areas where there are terminologies that haven't really been addressed yet. We started in some draft work that's being done by our Health IT Advisory Committee here at NQF, wearing that hat, there are some areas of

information that might be sitting out there in other areas, environmental health and how to deal with behavioral health that may well be handled in SNOMED and taxonomies we were talking about, but may open doors to new ones we haven't addressed; otherwise, I'd agree it's more quantitative than qualitative.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes. Now, one thing that may be a qualitative difference is if we think that the stage two requirements for both the certification and meaningful use will closely mirror many of the things that were essentially withdrawn from the final rule that were in previous iterations of rule making. Then that would open up the administrative simplification content sets of X-12 and so there would be, I think, a qualitative difference in terms of the scope of what we're talking about in that regard.

I guess the other thing I was thinking of in terms of the size of the problem is based on my assumption, possibly incorrect, that there would be more participants as we go further down into the program, so initially when things are by attestation and that there's no data submission actually on these measures, I think that's another aspect of it is that in the first year or two, until CMS is ready to actually receive data, there may be a different set of issues where people are just measuring things internally as opposed to actually sending data around.

Marc Overhage – Regenstrief – Director
Yes, I think that's a reasonable statement and I think if I were to think about measure developers creating these we may or may not be seeing more. We might actually see less, but I think what we are going to see is more individuals interested, because of implementation and having to get the detail directly out of the EHR if it's for meaningful use and reporting, there will be a larger number with that interest. I would agree with you.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
So is the point of that though then that it changes the economics; that we're spreading the costs more broadly and that we need to find a way for more people to contribute or will that happen naturally, because people have to pay a license fee to their vendor, who is paying a license fee? I'm not clear what the implications of that broader use might be.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes. I don't know. I don't think I thought that through either. I think it may be that if we're talking about cost issues, I mean if you're talking about implementation that's what I was talking about. I think one of the concerns is there needs to be mapping or whatever locally in the measures. But if we're talking license fees I'm not sure if there's implication there or not, so, Marc, I don't disagree with you. I'm not sure.

Marc Overhage – Regenstrief – Director
I guess, if anything, to me it implies that we need to find ways to support these things that recognize the broad need for them as opposed to sort of a one-off-end user model. If anything else, as you get broader you drive the cost up rather than down when the amount of support you need from, to be ridiculous, 600,000 physicians each paying $1 is a very inefficient way to collect $1. So finding ways to aggregate that and make that more efficient may become more— I don't know. I'm grasping a little bit to figure out where we take this.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes. Well, I have to say my own sense of it is that we really ought to figure out how to lay out a chart of who's paying for what standards now and what's different about meaningful use, back to Betsy's excellent suggestion, before we hypothesize how much of a problem it is or even solutions. How do others feel about that and just taking this to that analysis?

Marc Overhage – Regenstrief – Director

I think that will be useful, because it will call out the buckets that Clem was alluding to. I think that will be helpful.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay. Now, Betsy, you had mentioned that you were thinking of some possible resources to help with that analysis.

Betsy Humphreys – National Library of Medicine – Deputy Director
Well, I think that what I'm going to try to do is I guess what I want to see is whether there is some resource that relates to HIPAA that will help us just get a list. Do you see what I mean?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes.

Betsy Humphreys – National Library of Medicine – Deputy Director
That apply over there—

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes.

Betsy Humphreys – National Library of Medicine – Deputy Director
Then the issue, of course, that is embedded within them obviously are two kinds of coded data that are sent in these messages, some of which come from the big things, like CPT or ICD or whatever. Some of it comes from the code set that's maintained by X-12 or whatever, right?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right.

Betsy Humphreys – National Library of Medicine – Deputy Director
I mean the smaller code set or with HL-7 it's the same thing. So I'll see what I can do to get some help over here to just try to put together a draft matrix of what it is we're talking about.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I think that would be very helpful to help move this discussion forward, because I think we're all kind of grasping for—

Betsy Humphreys – National Library of Medicine – Deputy Director
Yes and one of the things that bothers me or shall we say is that every time I hear from any quarter the fact that no, a better way forward would be to have a central mechanism and people would pay in and they would cover all of these, the chills that go up and down my spine are are we really recommending that we undo what we're doing already.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes.

Betsy Humphreys – National Library of Medicine – Deputy Director
Obviously, that would not sit well with me personally, but I also feel that it's an unworkable solution. So I think that one of the things we need to tease out is whether anyone is seriously arguing that we change the method of support. If they're not arguing that we change it then it seems to me from a national policy point of view and the advisory committees and all of us, then there also has to be a recommendation that we leave it the way it is and that we make sure that it is adequately maintained so it will be left the way it is.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right\.

M
I think that's a key notion.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes. Absolutely.

Betsy Humphreys – National Library of Medicine – Deputy Director
Because I think that we are not in a very good economic position for anyone and if we don't see very austere budgets in the federal government coming up I will be a very surprised person. So I think the issue is is this a high priority to continue allocating resources so that we can continue to do the things we're doing or is it not or is it something that is absolutely critical to do; and I could potentially argue this point of view; that it's pretty critical for us to do and maintain what we're doing at least for N years and then do a reassessment about where the country is at that point and whether there's a better way to handle it going forward, but I do sort of feel like we could really upset the apple cart of moving ahead with meaningful use if we kind of undid things that are in place today.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Betsy, I'd be happy to help with that. One other thing that came out of the discussion I hadn't really thought about is that there is the current model, whether it's paid for ... tends to be a contact between certain kinds of users and the organization such that they can be informed of changes, etc. So we should think through what sub things really need any kind of attention, like sending a message out, I hope doesn't need any attention, but certain kinds of transfers might be good to know who is using it so one could keep connected with them.

Betsy Humphreys – National Library of Medicine – Deputy Director
Yes. That was an excellent point that Don made about that. I agree. I just think that, as I say, this will be very helpful, because when I ... some people say, "It's no problem. We can just charge people for it." They have a certain set of things in their mind and it's not necessarily the whole picture at all.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right. \Now, I guess one thing in terms of the scope of that matrix, I'd like to recommend that everything in the proposed rule, interim final, as well as final rule, should be considered, rather than just what we're dealing with in the final rule, because I think that will broaden it certainly, but it may end up then dealing with things that are under consideration for stage two.

Betsy Humphreys – National Library of Medicine – Deputy Director
Yes. I think if we do that and we include all of the stuff that's required for HIPAA, even though, obviously, some of it may not be directly addressed; I mean a lot of it is addressed; but if it isn't we'll include it there—

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right. It will at least address that model for some of the transactions.

Betsy Humphreys – National Library of Medicine – Deputy Director
Yes, because I think that we need to look at what we're already doing. As I say, sometimes, obviously, you can do something new that is, however, still really following an old model, but just extending it to a new thing. In some cases I think that's what we've done in this area and yet, some people look at it as if it is a vast departure from what's been going on.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay. Well, I think we've got some next steps, which I always like it when I don't have to do them. It sounds like Betsy and Floyd have the next steps that we've determined from this call.

Betsy Humphreys – National Library of Medicine – Deputy Director
Jamie, that's two calls in a row for you and me, so the next one it's all going to be on your plate.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I dread that, but okay.

Betsy Humphreys – National Library of Medicine – Deputy Director
I think I already owe you so many I shouldn't look at it that way.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Is this a successful conclusion for this call or is there further discussion that folks want to bring up?

W
What's the agenda for the meeting on Wednesday then?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Well, that's a very good question.

Betsy Humphreys – National Library of Medicine – Deputy Director
Yes. Jamie, I have a call with John Halamka after this and we're going to finalize that. What I have right now; I can't find it. Where is it? Just talking about mostly the meaningful use discussion, right? You're talking about the Standards Committee, right?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes. So my assumption, if it's okay with the Task Force members, is that I would just give a very brief status description of this call and where we are.

Betsy Humphreys – National Library of Medicine – Deputy Director
That's what I had you down for, Jamie.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
So I would just describe the analysis that Betsy is looking at, as well as the framework that Floyd discussed and just make it a very brief status update.

Betsy Humphreys – National Library of Medicine – Deputy Director
Okay.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
So if there is nothing else for this call then I think we're ready for any public comments, Judy.

Judy Sparrow – Office of the National Coordinator – Executive Director
Operator, can you see if there is anybody on the public line who wishes to make a comment, please?

Operator
We do not have any comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, operator, and thank you, Jamie and everybody.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Thank you, everybody. I appreciate your participation today. Thank you very much.

Judy Sparrow – Office of the National Coordinator – Executive Director

All right. Good-bye.